*DFRIHAE01*

# Application for Healthy Indiana Plan

State Form 53421 (10-07) / HIP 2515

*This agency is requesting the disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

HIP – the Healthy Indiana Plan – is a health insurance plan for adults. HIP provides a comprehensive package of benefits through private insurance providers. HIP enrollees pay a set amount each month into an account to cover a portion of their expenses. Enrollees who do not make monthly payments will be disenrolled and can not reapply for 12 months.
Note: Pregnant women and children do not complete this application but will use the Hoosier Healthwise application. Contact 1-877-GET HIP 9 (1-877-438-4479) for a copy of the Hoosier Healthwise application.

**1.** If you need help in choosing a health plan please call 877-438-4479. If you have made your health plan choice, please mark the box next to your chosen plan below.

☐ Anthem Blue Cross & Blue Shield ☐ MDwise with AmeriChoice

**2.** Tell us about adult members of your family living in your household. Place a √ in the last column if that person is applying for HIP.

| Name (First, MI, Last) | Date of Birth MM/DD/YY | *Social Security # | Marital Status M/D/S | Race | Sex M/F | Relationship to Applicant #1 | U.S. Citizen? Yes / No | Place a √ if applying |
|---|---|---|---|---|---|---|---|---|
| Adult / Applicant #1 | | | | | | *Self* | | |
| Adult / Applicant #2 | | | | | | | | |

**3.** Tell us about children living in your household.

| Name (First, MI, Last) | Date of Birth MM/DD/YY | *Social Security # | Applicant #1 is a caregiver of this child Yes/No | Applicant #2 is a caregiver of this child Yes/No | Race | Sex M/F | U.S. Citizen? Yes / No |
|---|---|---|---|---|---|---|---|
| Child #1 | | | | | | | |
| Child #1 Relationship to Applicant #1: | | | Child #1 Relationship to Applicant #2: | | | | |
| Child #2 | | | | | | | |
| Child #2 Relationship to Applicant #1: | | | Child #2 Relationship to Applicant #2: | | | | |
| Child #3 | | | | | | | |
| Child #3 Relationship to Applicant #1: | | | Child #3 Relationship to Applicant #2: | | | | |
| Child #4 | | | | | | | |
| Child #4 Relationship to Applicant #1: | | | Child #4 Relationship to Applicant #2: | | | | |

Completed by Enrollment Center:

Date of application:(mm, dd, yyyy)_____ Center's Code: _____ Interviewer: _____

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**4.** How many total members are in your household? _____

**5.** Applicant e-mail addresses: #1_____#2_____

**6.** Tell us your address and telephone number.

| Home address | City | State | ZIP code | County | Telephone number |
|---|---|---|---|---|---|
| | | | | | |
| **Mailing address (if different)** | **City** | **State** | **ZIP code** | **County** | **Telephone number** |
| | | | | | |

**7.** Do all of the applicants live in Indiana? ☐ Yes ☐ No

**8.** Does either of the applicants pay someone to care for a dependant child or a disabled/elderly adult so that a household member can work, look for a job or go to school? ☐ Yes ☐ No

If yes, does the person for whom the expense is being paid live in the household? ☐ Yes ☐ No

If no, go on to the next item. If yes, *enter out-of-pocket expenses only*, not expenses that are paid by a non-household member, or child care assistance agency.

| Applicant # | Name of person being cared for | How often paid | Amount paid |
|---|---|---|---|
| | | | |
| Name of care provider | | Address of provider (number and street, city, state, ZIP code) | |
| | | | |

**9.** Complete this section for each applicant who is not a citizen of the United States.

1. Lawful Permanent Resident
2. Refugee
3. Granted Political Asylum
4. Cuban/Haitian Entrant
5. Parolee
6. Amerasian
7. Undocumented
8. Other (specify)

| Applicant # | Document Number | Immigration Status (number from above) | Status Date (MM/DD/YY) | Country of origin | Date of entry into the U.S. (MM/DD/YY) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**10.** For each applicant please provide the following information.

| | Place a √ if Blind or Disabled | Place a √ if Pregnant | Applicant has access to insurance at employer (circle one for each applicant) | Covered by health insurance now (circle one) | Date applicant last had health insurance (MM/DD/YY) | Why was health insurance lost? Please write one of these reasons below; Loss of employment, Could not afford, Coverage limit reached, Company ended coverage, Non-custodial parent dropped insurance, Divorce, Other |
|---|---|---|---|---|---|---|
| Applicant #1 | | | Yes / No | Yes / No | | |
| Applicant #2 | | | Yes / No | Yes / No | | |

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**11.** Tell us how much total work income the applicant(s) earn.

| Applicant #1 | Applicant #2 |
|---|---|
| Start date (MM/DD/YY) | Start date (MM/DD/YY) |
| End date (MM/DD/YY) | End date (MM/DD/YY) |
| Amount of gross pay per period ($) | Amount of gross pay per period ($) |
| How often paid? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Twice a month ☐ Other: _____ | How often paid? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Twice a month ☐ Other: _____ |
| Hours worked per week | Hours worked per week |
| Is person self-employed? ☐ Yes ☐ No | Is person self-employed? ☐ Yes ☐ No |
| Do hours vary? ☐ Yes ☐ No | Do hours vary? ☐ Yes ☐ No |
| Name of employer and telephone number | Name of employer and telephone number |

**12.** Tell us if you or family members receive other income from the types listed here.
If your family has no income, initial here: _____.

| | | | |
|---|---|---|---|
| **A)** SSI<br>**B)** Social Security<br>**C)** Veteran's Benefits<br>**D)** Railroad Retirement<br>**E)** Pension | **F)** Military Allotment<br>**G)** Unemployment<br>**H)** Alimony<br>**I)** Sick Benefits<br>**J)** Strike Benefits | **K)** Interest Payments<br>**L)** Educational Income<br>**M)** Cash from Friends, Relatives, etc.<br>**N)** Worker's Compensation | **O)** Child Support<br>**P)** Employment income from children<br>**Q)** Other: _____ |

| Who receives the payments? (applicant # or child #) | What type of payments? (Use letter code from above) | How Often are Payments Received? | When did Payments Begin? | Amount of the Payments ($) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**13. Read carefully, then sign and date below.** I certify under penalty of perjury, that all the information I have provided is complete and correct to the best of my knowledge and belief. I hereby assign to the state of Indiana, my rights to medical support and payments for medical care which I have on behalf of myself and other persons under this application whose rights I can legally assign.

Applicant #1 signature: _____ Date: (MM/DD/YY): _____

Applicant #2 signature: _____ Date: (MM/DD/YY): _____

Signature of witness if signed with "X": _____

## Health Screening Questionnaire

**(This form must be filled out and signed for an Application to be deemed complete)**

To the best of your ability, please answer *either* "Yes" or "No" to the following questions by marking the box next to the appropriate answer. This information is being collected to determine whether you will be eligible for the Enhanced Services Plan. This plan will provide a high degree of coordinated medical care for persons with specialized health care needs. If you are otherwise found to be eligible for HIP, you cannot be denied coverage based on a medical condition. Answering "Yes" to any of the following questions will not prevent you from obtaining health coverage.

| **For each question below, circle only one answer for each applicant.** | **Applicant #1** | **Applicant #2** |
|---|---|---|
| **14.** In the last three years have you been diagnosed or actively treated for an internal Cancer? This includes but is not limited to cancers of the: brain; head or neck; throat; esophagus; larynx; lung; breast; stomach; intestines; colon; pancreas; liver or biliary tract; ovary; prostate; testicles; bladder; bone; or blood. | Yes / No | Yes / No |
| **15.** Have you ever been the recipient of an organ transplant including heart, lung, liver, kidney or bone marrow? | Yes / No | Yes / No |
| **16.** Are you currently on a transplant waiting list for one of the above organs or been advised that you will require such a transplant within the next 12 months? | Yes / No | Yes / No |
| **17.** Have you ever been diagnosed with or otherwise told by a medical professional that you have HIV, AIDS or the virus that causes AIDS? | Yes / No | Yes / No |
| **18.** Do you take or have you ever taken medication for HIV, AIDS, or the virus that causes AIDS? | Yes / No | Yes / No |
| **19.** Have you ever been diagnosed with aplastic anemia? | Yes / No | Yes / No |
| **20.** Do you require frequent blood transfusions due to a medical condition? | Yes / No | Yes / No |
| **21.** Have you ever been diagnosed with or are you being actively treated for hemophilia, or other rare bloodstream diseases including Von Willebrand's disease, or congenital factor VIII disorder? | Yes / No | Yes / No |

### AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize and direct the medical provider named below to release my individually identifiable health information to the Indiana Family and Social Services Administration (FSSA), including companies and persons it contracts within the administration of the Healthy Indiana Plan. Information concerning my medical care, treatment or advice including medical or other care records, diagnosis, pharmacy information, information about HIV or AIDS, as deemed necessary by FSSA to determine my eligibility for benefits under the HIP Enhanced Services Plan and to administer benefits under the plan may be released.

I further authorize that a photocopy or fax copy of this medical release may be used to obtain the information requested.

I expressly consent to the release of my social security number. I understand that this information is protected under Federal and State confidentiality and privacy regulations and cannot be disclosed without my written authorization unless otherwise provided for under the law. I understand that I may revoke this authorization at any time in writing, but if I do, revocation will not affect any actions already taken or uses or disclosure made before the revocation.

This authorization will expire fourteen (14) months after the date of my signature below or as long as I am covered under the plan, whichever is later, unless revoked by me.

Applicant #1 Signature: _____ Date: (MM/DD/YY): _____

Applicant #1 Printed Name: _____

Applicant #1 Provider name, address and phone: _____

Applicant #2 Signature: _____ Date: (MM/DD/YY): _____

Applicant #2 Printed Name: _____

Applicant #2 Provider name, address and phone: _____

All information collected will be treated as confidential pursuant to 470 IAC 1-2-7, 470 IAC 1-3-1, 42 CFR 431 Subpart F and 45 CFR 164 Subpart E.

HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

# Information to Get You Started

**Enclosed is your application for the Healthy Indiana Plan, a health coverage program for uninsured adults age 18 through 64. The steps to follow in applying for HIP are explained below.**

**Step 1: Complete and sign the application.**

Answer ALL questions truthfully and completely to the best of your knowledge, including the Health Screening Questionnaire. Use only black or blue pen.

**Gather and copy any of the documents listed below as proof of the information on your application.**

Sending these papers with your application will help us process it faster. Write your name and social security number on all copies of documents that you send with your application.

| To provide proof of… | Send for each person applying … |
|---|---|
| **Identity** | Valid driver's license or state or student photo ID card. If you have someone acting on your behalf, that person will need to provide proof of his or her identity also. |
| **US citizenship** | Legal birth certificate, Certificate of Naturalization, Certificate of Citizenship, or U.S. passport if it was issued with no restrictions. |
| **Money received by applicant, spouse, and dependent children in the home** | **Wages:** Pay stubs, paychecks, or statement from employer(s) for the most current month; **Employment termination:** A statement from last employer giving dates of employment and reason for termination.<br>**Self-employment**: Last year's signed tax return or personally kept self-employment records.<br>**Child Support, Social Security, VA, SSI, Workers' Compensation, disability, sick pay, unemployment, or other benefits:** Court order, award letter or other proof of payment from the source of the income.<br>**Loans, gifts, or contributions:** Promissory note; loan agreement; or statement from person providing the money that includes the person's name, address, phone number, signature, and date. |
| **Guardianship or Power of Attorney** | If someone has legal authority to act on your behalf, provide a copy of the Power of Attorney, Guardianship Order, Court Order, or similar documents. |
| **Immigration Status** | If you are not a US citizen, a copy of your alien registration card, permanent resident card, or other documentation from the Bureau for Citizenship and Immigration Services (formerly the INS). |

**Step 2: Return the application.** You can return your completed application and other documents to us by:

- ✓ Mailing them to the Document Center at: **FSSA Document Center / PO Box 1630 / Marion, IN 46952; or**
- ✓ Faxing them to the Document Center at 1-800-403-0864; or
- ✓ Dropping them off at a local FSSA DFR office. To find a local office, please go to our Web site at **www.in.gov/fssa/dfr** or call toll free 1-800-403-0864.

**Step 3: Cooperate with requests for more information or interviews.** We will contact you by telephone or mail if we need additional information or documentation to complete your application. Please respond quickly to requests for additional information so that we can process your application.

## IMPORTANT INFORMATION ABOUT THE HEALTHY INDIANA PLAN

***Keep this information for your records. Do not send it in with your application.***

Benefits under the Plan

HIP provides health insurance coverage to eligible adults. Enrolled members keep their HIP benefits for 12 continuous months even if income or family size changes. Members must live in Indiana and have no other access to health insurance coverage. Benefits are provided through private health insurance companies and also through the State's Enhanced Services Plan (ESP) for members who have complex medical needs. You can choose your health plan on the first page of the application, or you can call the HIP Line at 1-877-GET-HIP-9 (1-877-438-4479) to get further information about the plan and to register your choice. If you do not select a health plan, one will be chosen for you. Members with complex health care needs will be assigned to the ESP so that enhanced disease management services and specialized networks can be accessed. An applicant's health condition has no bearing on the HIP eligibility decision. If FSSA determines that the ESP is not the appropriate health plan, the member's coverage will be transferred. Benefits will not lapse when the plan is changed from ESP to another HIP health plan.

HIP members have a POWER Account of $1,100 that will be used to pay for their initial health care expenses. The State will contribute to the account and members pay a small percentage of their income (2% - 5%) according to a sliding scale based on family income. When an application is approved, the new member is notified in writing of the amount of the POWER payment.

Your POWER Account payment will stay the same during your 12-month enrollment period unless you report a change and specifically ask that your payment be recalculated. During the 12-month enrollment period, you can request 1 recalculation only for changes in your income. This limitation does not apply to changes in your family size. **You must make your POWER Account contribution each month. Failure to pay may result in termination from the program, and once terminated due to failure to pay, a person cannot come back to the program for 1-year.**

**For Additional Information about the Healthy Indiana Plan, call us at 1 (877) GET-HIP 9 (1-877-438-4479) Toll Free**

Your Rights and Responsibilities as a HIP Applicant and Member

1. Once your signed application is received, federal rules allow 45 days for a decision to be made on your eligibility. We will send you a written notice explaining whether or not you qualify for HIP. You may appeal and have a fair hearing if you disagree with any decision on your eligibility or if your application is not processed in 45 days.

2. Information you give on the application is kept confidential under state and federal law.

3. A social security number (SSN) must be given for each applicant who can legally have a number. An applicant who does not have a number must apply for one. Your SSN will be used to check information kept by the Social Security Administration, the Internal Revenue Service, Workforce Development and other state and federal agencies. We ask for the SSNs of family members not applying for HIP for identification purposes; however, you are not required to provide the number.

4. Eligibility for benefits is considered without any regard to race, color, sex, age, disability or national origin. We ask about your racial-ethnic heritage to comply with the Federal Civil Right Law; however you are not required to provide this information. If you choose not to provide this information we will indicate an ethnicity/race category for you for data collection purposes.

5. Certain information given on your application, such as your income must be verified. If you cannot get the necessary papers, you will need to sign a release form so that we can get them for you.

6. You must provide accurate information. A person who gives false information or misrepresents the truth is committing a crime and can be prosecuted under federal law or state law, or both. The value of benefits received by a person who was not entitled to receive them is subject to recovery by the State.

7. IF YOU MOVE, please tell us your new address so that important mail about your application and membership will reach you without delay. Also, you must tell us if you get health insurance from another source such as Medicare, or if your employer offers health insurance coverage.

8. The immigration status of non-citizens who are applying for HIP is subject to verification by the Bureau of Citizenship and Immigration Services (CIS). Undocumented immigrants and lawful permanent residents who have not yet lived in the U.S. for 5 years are not eligible for full HIP benefits. HIP does not report undocumented immigrants to the CIS.

9. You are required to assign your medical rights. This includes rights to medical support and payment for any medical care that you have on behalf of yourself or your children receiving Hoosier Healthwise/Medicaid. If you do not do this, your application will be denied.

10. If you believe that you have been discriminated against and wish to file a complaint, you may do so by contacting the Department of Health and Human Services, Regional Manager, Region V, Office for Civil Rights, 233 N. Michigan Ave., Suite 240, Chicago, Illinois, 60601. You may call the Regional Office at (800) 368-1019 or, for TDD Call, (800) 537-7697.